PROFESSIONAL REVIEW POLICY

TO: All Carriers, Service Companies, and Review Companies
FROM: Health Care Services Division
SUBJECT: Requirements for Professional Review Certification Methodology

The Health Care Services rules require that the Health Care Services division of the Workers' Compensation Agency certify the carrier's professional review program. This certification is renewable every three years or whenever a change in the review process occurs. The purpose of professional review is to ensure that services are related to the covered work injury and that the carrier is reimbursing for medically necessary and appropriate medical care in accordance with section 315 of the Workers' Disability Compensation act and the Health Care Services rules. The General Provisions of the rules, R 418.10101, establishes that carriers will review the quality and quantity of medical services, based on accepted medical standards. This rule also allows carriers to dispute services that are not medically appropriate or related to the covered work injury.

The certification process requires that the carrier submit their review methodology to Health Care Services every three years. If in a three-year period there is a change in service company, review company or review process then a new application, WCA-590, is necessary to remain in compliance. The methodology **need not** be included with the application if it is already on file and current with the Health Care Services division.

The methodology should include documentation of compliance with Part 12 and Part 13 of the Health Care Services Rules. Also required is a copy of the EOB sent to providers and the injured worker. A copy of the Carrier's Explanation of Benefits, WCA-739, is available on this website. Health Care Services must approve any variance from this form.

Failure to submit methodologies may result in a conditional approval or disapproval for the carrier (R418.101207).

The **elements necessary** to include in the **technical review** section of the methodology (R418.101203) are:

- Determine accuracy of coding. Any reason for recoding a procedure shall be communicated to the provider within 30 days of receipt of the bill under Part 13 of the Health Care Services Rules.

- Determine that the amount paid for a procedure does not exceed the maximum allowable payment established by the rules. The carrier, or the designated agent is totally responsible for the technical computer review that is performed in accord with the rules. Include the name of the software program used in technical review when appropriate.

- Identify those bills and case records, which, under R418.101205, shall be subject to professional health care review.

Necessary elements to include in the **professional review** section of the methodology (R418.101204) are:

- **Non-clinical Staff:** Non-clinical staff (R 418.101204(5b)) may be used in the application of criteria (based on sound clinical principles and processes) developed by licensed, registered, or certified health care professionals in the review process. They may not gather data that

requires evaluation or interpretation of clinical information. Their duties must have oversight by a licensed health professional. They must be properly trained in the principles and procedures of structured clinical data, scripted clinical screening, and maintenance of confidentiality of patient-specific information. A mechanism to promptly move any call to a licensed health professional must be in place in the event the review cannot be completed based on the outlined criteria.

- **Professional (Utilization) Review:** Outline compliance with R 418.101205. Medical claims review demonstrates that the review is retrospective, and is performed strictly for purposes of reimbursement. The review may include determining medical necessity, appropriateness and efficiency of services, coding accuracy, coverage issues and appropriateness of billing. An RN or other licensed professional with suitable occupational injury and/or disease expertise must perform professional review and be involved in determining the carrier's response to a request by a provider for reconsideration of its bill. There must be support by a doctor of medicine or a doctor of osteopathic medicine in the professional review process.

- **Peer Review:** Peer review may be performed when the claims are initially submitted. Peer clinical review is usually done in cases where clinical determination to approve claim payments cannot be made by initial clinical review. Either a carrier or the physician may request a peer review if the outstanding claim issues are not resolved through the written reconsideration process. Peers must have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided. They must be in the same licensure category as the ordering provider or a doctor of medicine or doctor of osteopathic medicine.

- **Licensure:** For each licensed individual doing professional review and peer review for the carrier, submit documentation with the full name, professional license number, state of issue, date of expiration and any restrictions on current licensure. Include the same documentation on the medical/clinical director supporting reviewers. It is encouraged that any certification in bill review, utilization management (i.e., URAC, etc.) or personnel having any utilization management/review credentialing (i.e., CCM, CPUR) be included.

- **Reconsideration/Appeals:** Document the process (with time lines) used when a carrier, or their designated agent, adjusts or rejects a bill or a portion of the bill. Notification shall include an explanation of the appeal process provided under the Health Care Services Rules, including the fact that a magistrate of the Department of Labor & Economic Growth shall conduct any requested administrative appeal hearing. (R 418.101301-101305).

- **Confidentiality:** Document the process in place that ensures confidentiality of worker-specific and provider-specific information.

REMINDER: Claims may not be denied solely on the basis that no prior authorization was obtained. Michigan law does not mandate case management and does not require prior authorization of services.

IT IS THE CARRIER'S RESPONSIBILITY FOR SIGNING THE APPLICATION FOR CERTIFICATION OF A CARRIERS' PROFESSIONAL HEALTH CARE REVIEW PROGRAM APPLICATION.

If you have any questions regarding the above information or requirements please call Michelle Mapes in the Health Care Services Division at (517) 322-5430.